STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		08/31/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-
\/A   D	ALCO CADE AND D	ELIADU ITATION OFNITED	606 WA		
	AISO CARE AND R	EHABILITATION CENTER	VALPA	RAISO, IN46383	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE COMPLETION DATE
	REGULATORY OR	LISC IDENTIFFING INFORMATION)	IAG	BERTOLENOT,	DATE
F0000					
	This visit was fo	r the Investigation of	F0000	The creation and submission o	of this
	This visit was for the Investigation of Complaint IN00095374.		10000	Plan of Correction does not	
	Complaint II voo	0,55,71.		constitute an admission by this	• • • • • • • • • • • • • • • • • • •
	Complaint IN00	095374 substantiated,		provider of any conclusion set	
	•	iciencies related to the		in the statement of deficiencies any violation of regulation.	S, OF OI
		ited at F157, F241, F246,		any violation of regulation.	
	F309, F323, F32			This provider respectfully requ	iests
	1 307, 1 323, 1 32	5, und 1 441.		that the 2567 Plan of Correction	
	Survey dates: August 30, and 31, 2011			considered the Letter of Credit	• • • • • • • • • • • • • • • • • • •
	Survey dates: August 30, and 31, 2011			Allegation and requests a post desk review on or after Septen	
	Facility number:	000083		30, 2011.	libei
	Provider number			30, 2011.	
	AIM number: 10				
	Alivi liullioet. 10	00289070			
	Survey team:				
	Sandra Haws, R	N TC			
	Sanura Haws, Ki	N- IC			
	Census bed type	_			
	SNF/NF: 157	•			
	Total: 157				
	101. 137				
	Census payor ty	ne:			
	Medicare: 25	μ.			
	Medicaid: 120				
	Other: 12 Total: 157				
	Total: 157				
	Sample: 4				
	•	mnla: 20			
	Supplemental sa	inpie. 38			
	Thoso deficient	es also reflect State			
	rindings cited in	accordance with 410 IAC			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DJTL11

Facility ID:

000083

TITLE

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		08/31/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		=	606 W/		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER	VALPA	RAISO, IN46383	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	16.2				
		ompleted on September			
	7, 2011 by Bev F	Faulkner, RN			
	1				
F0157	•	nediately inform the			
SS=D	· · · · · · · · · · · · · · · · · · ·	vith the resident's physician; fy the resident's legal			
		an interested family member			
	•	accident involving the			
		ults in injury and has the			
		ing physician intervention; a			
		in the resident's physical,			
	deterioration in he	social status (i.e., a			
		is in either life threatening			
		cal complications); a need to			
		nificantly (i.e., a need to			
		sting form of treatment due			
		quences, or to commence a			
		nent); or a decision to ge the resident from the			
	facility as specified				
	,	<b>G</b> ( )			
		lso promptly notify the			
		own, the resident's legal			
	· ·	nterested family member			
		ange in room or roommate ecified in §483.15(e)(2); or			
		ent rights under Federal or			
		ations as specified in			
	paragraph (b)(1)	of this section.			
	The feetile	and and and a W. W.			
		ecord and periodically as and phone number of the			
		oresentative or interested			
	family member.	J. J			
	-	ew and record review, the	F0157	E457	09/30/2011
		ensure the physician was		F157	
		F 2			

II .		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		00	COMPLETED
		155166	B. WIN	G		08/31/2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	notified of a critifor 1 of 4 resider notification in a set of the	cally low blood pressure its reviewed for physician sample of 4. Resident #  coord was reviewed on i.m. The resident's record ses of, but not limited to;			CROSS-REFERENCED TO THE APPROPR	of  vider to dent, tify the ive or er  cian hange hental, eed to gor a harge //.  Il be ents by the ction he was es at
	dated 7/22/11, in (a test to check h normal reading ( physician's order Warfarin for 3 da	othrombin Time Report, dicated "Protime 70.0" low thin your blood is) 9.1-12.5). The indicated to hold the ays and give vitamin K 10 th) every 8 hours, times 2			affected by the same deficien practice and what corrective action will be taken  Residents with change condition have the potential affected by the alleged deficipractice.  Licensed nurses notific	in to be ent
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	DJTL11	Facility	ID: 000083 If continuation	sheet Page 3 of 34

NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEPICIENCES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COME - 08/31/	PLETED	
PREFIX   GRACH DEFICIENCY MIST BE PERCEDED BY FULL   PREFIX   CROSS REFERENCED TO HAPPROPRIATE   COMPLETION DATE				606 WA	ALL ST	DE	
Nurses note on 7/23/11 at 4 a.m., indicated "97.1 (temperature), 50 (pulse), 24 (respirations), 75/50 (blood pressure) (normal 120/70), Coumadin (Warfarin) (a blood thinner) on hold. No bleeding noted, no black tarry stools noted" The note failed to indicate the resident's critical blood pressure of 75/50 and a low pulse of 50 was called to the physician. The record further lacked documentation to indicate the resident's blood pressure and heart rate was being monitored.  During an interview with the Director of Nursing on 8/31/11 at 11:30 a.m., regarding the resident's critical blood pressure of 75/50 and the lack of documentation to indicate the physician was notified, she indicated the nurse who documented the critically low blood pressure should have called the doctor immediately.  This Federal tag relates to Complaint # IN00095374  3.1-5(a)(2)  condition. The resident is assessed and monitored until the condition is reviewed by the interdisciplinary team utilizing the 24 Hour Report Sheets and Physician Telephone Orders, Monday through Friday. The nurse on-call is notified of resident change of status on the weekends/holidays. The nurse managers ensure the physician is notified and appropriate interventions are initiated, as needed.  Licensed nurses will be educated to the facility Change of Condition Dry and Procedure, Physician Telephone Orders and the 24 Hour Report Sheets by the Director of Nursing Services or designee by 9/30/11.  Noncompliance with facility policy and procedure will result in employee education and/or disciplinary action up to and including termination.  What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur	PREFIX	(EACH DEFICIEN	EIENCY MUST BE PERCEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE COI CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
designated shift and notes any change of resident status. The Physician Telephone Orders form is utilized for physician orders or		Nurses note on 7 indicated "97.1 (24 (respirations), (normal 120/70), blood thinner) or noted, no black to note failed to indicate the reand heart rate was During an intervinuous of 50 was of The record further to indicate the reand heart rate was During an intervinuous of 75/50 documentation to was notified, she documented the opressure should himmediately.  This Federal tag IN00095374	/23/11 at 4 a.m., temperature), 50 (pulse), 75/50 (blood pressure) Coumadin (Warfarin) (a hold. No bleeding arry stools noted" The icate the resident's essure of 75/50 and a low called to the physician. er lacked documentation sident's blood pressure as being monitored.  The icate the resident's essure of 75/50 and a low called to the physician. Every lacked documentation sident's blood pressure as being monitored.  The with the Director of 11 at 11:30 a.m., ident's critical blood and the lack of the indicate the physician indicated the nurse who critically low blood have called the doctor		condition. The residen assessed and monitored condition stabilizes.  A change of reside condition is reviewed by interdisciplinary team up 24 Hour Report Sheets as Physician Telephone Or Monday through Friday nurse-on-call is notified change of status on the weekends/holidays. The managers ensure the ph notified and appropriate interventions are initiate needed.  Licensed nurses weeducated to the facility of Condition Policy and Prephysician Telephone Or the 24 Hour Report Shedirector of Nursing Serdesignee by 9/30/11.  Noncompliance weeding and procedure with employee education and disciplinary action up to including termination.  What measures will be place or what systemic of you will make to ensure deficient practice does not the 24 Hour Report on the 25 Hour Report on the 26 Hour Report on the 27 Hour Report on the 28 Hour Report on the 29 H	to the until the ent of the utilizing the and ders, or The of resident enurse system is eed, as will be Change of recedure, ders and ets by the vices or ith facility ill result in lor or and enurse enter the enurse completes their essany s. The ders form	

	T OF DEFICIENCIES  DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPLETED 08/31/2011	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE	
				changes in resident status that require a change in the reside plan of care. Notification of and physician is recorded on form.  The Interdisciplinary will review the 24 Hour Report and Physician Telephone Order form for physician and family notification Monday - Friday (excluding holidate clinical meeting. The interdisciplinary team determ if any further interventic changes to the plan of care is necessary. The Unit Manager or designee with ensure implementation and compliance.  The Nurse Manager or will be notified of acute reside change of status during non-business hours. The Nur Manager on call will notify the Director of Nursing Services and/or the Executive Directoneeded.  The Director of Nursing Services and/or the Executive Directoneeded.  How the corrective action(s) be monitored to ensure the deficient practice will not recite, what quality assurance program will be put into place.  The Physician Telepho Orders and the 24 Hour Repsheets are audited by the Unit Managers and/or designee to	ent's family this  team ort e d	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/31/2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				ensure resident change of condition is reported to the physician, physician orders ar followed through timely and c plans are updated.  The Unit Manager will complete a "24 Hour Condition Report" CQI tool. It will be utilized daily x 4  weeks, weekly x 8 weeks monthly thereafter for 3 mont monitor family and physician notification compliance. The audits are reviewed by the DNS/CQI committee and action plans are developed to improve performance, which will inclued ucation, skills validations, performance improvement, and disciplinary action.	n s, hs to
F0241 SS=D	a manner and in a maintains or enha and respect in full individuality.  Based on observe facility failed to treated with resp a staff member (a resident's requel 1 resident's reviedignity in a sample Findings include	romote care for residents in n environment that nees each resident's dignity recognition of his or her ation and interview, the ensure a resident was ect and dignity related to CNA #5) failing to honor est for fresh water for 1 of wed for respect and ole of 4. (Resident # TT)	F0241	F241 DIGNITY AND RESPECT INDIVIDUALITY The facility must promote care residents in a manner and in an environment that maintains or enhances each resident's dignit respect in full recognition of his her individuality.  What corrective action(s) will accomplished for those resider found to have been affected by deficient practice	for  y and s or  be nts

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155166	B. WIN			08/31/2011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	R		606 WA	ALL ST		
	AISO CARE AND R	EHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION  (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	PLETION
TAG	-	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	<u>D</u>	OATE
		nt # TT on 8/31/11 at			· There is no corrective ac	ion	
	12:05 p.m., she indicated the pitcher of water that was sitting on her bedside table was 2 days old. She further indicated staff do not always bring fresh water daily.  During the interview with Resident # TT,  CNA # 5 came into the resident's room to deliver a lunch tray. CNA # 5 was made aware the resident was requesting some				as the alleged deficient practice	I	
					in the past. Residents who are a		
					have fresh water are provided f	esh	
					water every shift.		
					11		
					How will you identify other residents having the potent	lei.	
					to be affected by	lai	
					the same deficient practice	and	
	fresh water. CNA # 5 replied "This isn't				what corrective action will	I	
	my resident or my hall, you'll have to find the person that works this hall." CNA # 5				taken		
	1 -	walked out of the			· All residents have the		
	resident's room.	warked out of the			potential to be effected by th alleged deficient practice. A		
	l resident s room.				residents who are able to ha		
	Danin a an intan	in and the CNIA # 5 are			fresh water are provided it ev	I	
		riew with CNA # 5 on			shift and as requested.	, I	
		p.m., regarding not			· C.N.A. #5 received		
	1	ent # TT's request for fresh			inservicing and disciplinary a	I .	
		ne very angry and			<ul> <li>All staff will be inservious on Resident Rights by the</li> </ul>	æd	
	•	y someone else was			SDC/designee before 9/30/1	1.	
	passing water.						
					What measures will be put ir		
	During an interv	view with the Director of			place or what systemic chan	-	
	Nursing on 8/31	/11 at 1:00 p.m.,			you will make to ensure that	I .	
	regarding reside	nts having fresh water,			deficient practice does not re	Gui	
		esh water is to be passed			· Unit Managers monito	r	
		ose residents able to have			resident care by making rour		
	water and the water should be accessible to them.  This Federal tag relates to Complaint #				on their units daily which inc	ude	
					the passing of fresh water.		
					Concerns are addressed with nursing aide, as needed.	ı ıne	
					Rounds are completed		
	IN00095374	relates to Complaint #			each shift by the charge nurs	I .	
	111000933/4				daily and by department hea		
	3.1-3(t)				Monday - Friday to monitor		
	J.1-J(l)		1		Ī	ı	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY  COMPLETED	
		155166	A. BUILDING B. WING		08/31/2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				resident care. Concerns are addressed with the aides chanurse utilizing an inservice a disciplinary action.  How the corrective action(s) be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place. Nurses will document rounds on the "Resident Car Rounds" daily. The DNS will review the checklist daily Money and the side of the sid	arge nd/or  will  ur, e their e
F0246 SS=E	services in the fac accommodations of preferences, exce of the individual or	right to reside and receive ility with reasonable of individual needs and pt when the health or safety other residents would be		document on the "Customer Rounds" sheets daily. The Content Relations Coordinator/design will review the round sheets weekly and it will be ongoing.  Data will be submitted the CQI Committee for reviewand follow up.  Noncompliance with far procedures will result in disciplinary action.	Care Guest nee  to
	observations, the residents in the fa had the water acc the 85 residents of drink water in the (Resident's # F, #	ews, record review and facility failed to ensure acility had fresh water or essible to them for 34 of observed who are able to the facility.  ### G, # H, # I, #J, #K, #L, ##Q, #R, #S,#T,#U, #V,	F0246	F246 REASONABLE  ACCOMODATION OF  NEEDS/PREFERENCES  A resident has the right to residenceive services in the facility of reasonable accommodations of individual needs and preference except when the health or safety the individual or other residents.	vith ss,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SU	URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	TED
		155166	B. WIN			08/31/20	11
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	· ·		606 WA	ALL ST		
	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL				TE	COMPLETION
TAG	<b>†</b>	LISC IDENTIFYING INFORMATION)	+	TAG		$\longrightarrow$	DATE
	#W, #X,#Y,#Z, #A, #ZZ, #FF, #GG,				would be endangered.		
		KK, #LL, #MM, #NN,					
	#RR, and # TT.	)			What corrective action(s) will	be	
	Findings include :				accomplished for those resider		
					found to have been affected by	y the	
					deficient practice		
	During a tour of	the facility on 8/30/11 at			There is no corrective a	oction	
	8:00 a.m., accon	npanied by the Staff			There is no corrective a as the alleged deficient prac		
	Development Coordinator # 6 and LPN # 7, in an interview with Staff Development Coordinator # 6 at the start of the tour, she indicated the following resident's were able to drink thin water, and none of the following residents were on any type of				was in the past. Reside		
					who are able to have		
					<ul> <li>fresh water are provide</li> </ul>		
					fresh water every shift and a		
					requested.		
	· ·	The following was			How will you identify other		
		<u> </u>	residents having the potential				
	· ·	a tour of the resident	to be affected by the same				
	rooms on both th	ne east and west halls:			deficient practice and what		
					corrective action will be tak	(en	
		room was observed			All registers to accept the		
	1	er in the resident's room			<ul> <li>All residents have the potential to be effected by th</li> </ul>	ا م	
	or on the residen	t's bedside table.			alleged deficient practice.	`	
					Residents who are able to ha	ave	
	2. Resident # G's	s room was observed			fresh water are provided fres	sh	
	without any water	er in the resident's room			water every shift.		
	or on the residen	it's bedside table.			<ul> <li>All staff will be inservious on Hydration and Accommod</li> </ul>		
					of Needs by the SDC/design		
	3. Resident # H's	s room was observed			before 9-30-11		
	without any water in the resident's room or on the resident's bedside table.						
					What measures will be put	into	
					place or what systemic		
	4 Resident # I's	room was observed			changes you will make to		
		er in the resident's room			ensure that the deficient practice does not recur		
	1	at's bedside table.			practice does not recal		
	or on the residen	n s deusiue ladie.			· Unit Managers monito	r l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		08/31/2011
NAME OF I	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	FROVIDER OR SUFFLIER			VALL ST	
		EHABILITATION CENTER		ARAISO, IN46383	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
IAG		,	IAG	resident care by making ro	
	<ul><li>5. Resident # J's room was observed without any water in the resident's room or on the resident's bedside table.</li><li>6. Resident # K's room was observed</li></ul>			on their units daily. Conce	
				addressed with the nursing	
				as needed.	
				Rounds are complete	l l
				each shift by the charge no and by department heads	irse
		er in the resident's room		Monday - Friday to monito	r
	or on the residen	t's bedside table.		resident care. Concerns a	re
				addressed with the aides of	- 1
	7. Resident # L's room was observed			nurse utilizing an inservice disciplinary action.	and/or
without any water in the resident's room			How the corrective action	n(s)	
or on the resident's bedside table.			will be monitored to ensu	· ·	
				deficient practice will not	recur,
		s room was observed		i.e., what quality assuran	
	· ·	er in the resident's room		program will be put into p	place
	or on the residen	t's bedside table.		Nurses will docume	nt their
				rounds on the "Resident C	
	9. Resident # N's	room was observed		Rounds" daily. The DNS v	l l
	without any wate	er in the resident's room		review the checklist daily N	l l
	or on the residen	t's bedside table.		<ul> <li>Department heads videocument on the "Custome</li> </ul>	
				Rounds" sheets	el Gale
	10. Resident # O	's room was observed		daily. The Guest Relations	s
	without any water	er in the resident's room		Coordinator/designee will	l l
	or on the residen	t's bedside table.		the round sheets weekly o	• •
				<ul> <li>Data will be submitted the CQI Committee for rev</li> </ul>	
	11. Resident # P'	s room was observed		and follow up. Actions plar	
	without any water	er in the resident's room		be developed if thresholds	
	or on the residen	t's bedside table.		obtained.	£==:104.
				<ul> <li>Noncompliance with procedures will result in</li> </ul>	racility
	12. Resident # Q	's room was observed		disciplinary action.	
	without any water	er in the resident's room		, ,	
	or on the residen	t's bedside table.			
	13. Resident # R	's room was observed to			
	have a pitcher of	water on a bedside table			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155166			LDING	NSTRUCTION  00	(X3) DATE S COMPL 08/31/20	ETED
NAME OF I	PROVIDER OR SUPPLIEI	<u> </u>	р. үүн		ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
		EHABILITATION CENTER			RAISO, IN46383		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	that was across t	he room out of the					
	resident's reach. During an interview with						
	the Staff Development Coordinator # 6 during the tour about Resident # R, she indicated the resident falls frequently and needs assistance.						
	14. Resident # S's room was observed without any water in the resident's room						
	or on the resident's bedside table.						
	15. Resident # T's room was observed						
	without any wat	er in the resident's room					
	or on the resider	nt's bedside table.					
	16. Resident # U	J's room was observed					
	without any wat	er in the resident's room					
	or on the resider	nt's bedside table.					
	17. Resident # V	's room was observed					
	1	er in the resident's room					
	or on the resider	at's bedside table.					
	18. Resident # V	V's room was observed					
	1	er in the resident's room					
	or on the resider	it's bedside table.					
		I's room was observed to					
		t's water across the room,					
	out of the reside	nt's reach.					
	20. Resident # Y	's room was observed					
	1	er in the resident's room					
	or on the resider	t's bedside table.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  1/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET 606 W	ADDRESS, CITY, STATE, ZIP ALL ST RAISO, IN46383	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	21. Resident # Z	s room was observed er in the resident's room				
		's room was observed er in the resident's room t's bedside table.				
	<ul> <li>23. Resident # ZZ's room was observed to have a pitcher of water across the room, out of the resident's reach.</li> <li>24. Resident # FF's room was observed without any water in the resident's room or on the resident's bedside table.</li> <li>25. Resident # GG's room was observed without any water in the resident's room or on the resident's bedside table.</li> <li>26. Resident # HH's room was observed without any water in the resident's room or on the resident's bedside table.</li> </ul>					
		's room was observed er in the resident's room t's bedside table.				
	without any water or on the resident an interview with	's room was observed er in the resident's room t's bedside table. During in the Staff Development during the tour about				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	ì	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP ALL ST RAISO, IN46383	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	1	e indicated the resident and needs assistance.				
	1	K's room was observed coss the room out of the				
	without any water	L's room was observed er in the resident's room t's bedside table.				
	31. Resident # MM's room was observed to have a pitcher of water on a bedside table that was across the room out of the resident's reach.					
	without any water	N's room was observed er in the resident's room t's bedside table.				
	33. Resident # RR's room was observed without any water in the resident's room or on the resident's bedside table.					
	During an interview with LPN # 7 on 8/30/11 at 11:15 a.m., regarding the residents still not having any water, she indicated the water is usually passed every					
	shift and there she the resident's root indicated the nig up the pitchers a	nould have been water in				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155166	A. BUIL	DING	00	08/31/2	
		133100	B. WIN		PRESIDENCE CONTROL CON	00/31/2	011
NAME OF I	PROVIDER OR SUPPLIER			606 WA	ADDRESS, CITY, STATE, ZIP CODE		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER		l	RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	ents either didn't have any					
	water or it was not in their reach on both						
	east and west units, she indicated they should have had water this morning.						
	On 8/31/11 at 11						
		ents still remained					
		ter being delivered to					
		ing an interview with					
		n 8/30/11 at 2:10 p.m.,					
	regarding having fresh water available, he						
	indicated they do not always pass the						
	water when they						
	Resident # ZZ po	ointed across the room at					
	a pitcher of water	r and indicated it had					
	been there since	yesterday.					
	During an intervi	iew with alert and					
	~	t # TT on 8/31/11 at					
		ndicated the pitcher of					
		tting on her bedside table					
		She further indicated staff					
		ing fresh water daily.					
	1	view with Resident # TT,					
	~	nto the resident's room to					
		ray. CNA # 5 was made					
		nt was requesting some					
		A # 5 replied "This isn't					
		y hall, you'll have to find					
	l -	orks this hall." CNA # 5					
	then turned and v	walked out of the					
	resident's room.						
		: ONTA # 5					
	During an intervi	iew with CNA # 5 on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMP: 08/31/2	LETED	
	PROVIDER OR SUPPLIEF	EHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP COD ALL ST RAISO, IN46383	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERNCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
IAU	8/31/11 at 12:30 honoring Reside water, she becan indicated harshly passing water.  During an interv Nursing on 8/31/regarding residers she indicated freevery shift to the water and the water and the water and the water to them.  The facility's pol Management" reon 8/31/11 at 1:2 indicated " Freall residents, unle contraindicated, Additional fluids various times the medication pass, request"	p.m., regarding not nt # TT's request for fresh ne very angry and y that someone else was  iew with the Director of /11 at 1:00 p.m., nts having fresh water, sh water is to be passed ose residents able to have nter should be accessible  licy titled "Hydration evised 6/11 was reviewed 20 p.m. The policy esh water will be passed to				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLE CC  A. BUILDING  B. WING	00 	COMP 08/31/2	LETED		
VALPARA		EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155166	B. WIN	G		08/31/2	011
VALPAR/	PROVIDER OR SUPPLIER	EHABILITATION CENTER		606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION  (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG			DATE
F0309 SS=D	must provide the material fibrillation, weakness, history accident, impaired not set to attain or maintal physical, mental, at in accordance with assessment and physical passed on intervite facility failed to a pressure was proposed to be considered with blain a sample of 4.  Findings includes the second indicated of the considered to the	ew and record review, the ensure a resident's blood perly monitored prior to in of 2 blood pressure a blood pressure itically low just a few ministering the 2 blood ions for 1 of 4 residents cood pressure medications. Resident #B  cord was reviewed on in.m. The resident's diagnoses of, but not try, anemia, dementia, congestive heart failure, y of cerebral vascular	F0	309	F309 PROVIDE CARE/SERVICES HIGHEST WELL BEING Each resident must receive and facility must provide the necess care and services to attain or maintain the highest practicable physical, mental, and psychosoc well-being, in accordance with comprehensive assessment and of care.  What corrective action(s) will accomplished for those resident found to have been affected by deficient practice  There is no corrective act for resident #B since the alleged deficiency was in the past and no longer resides at the facility.  How will you identify other residents having the potential affected by the same deficient practice and what corrective action will be taken  All residents have the potential to be affected by the all deficient practice.  Nurses will be educated	the ary	09/30/2011

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		08/31/2011
		l .		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	t		ALL ST	
VAI PAR	AISO CARE AND R	EHABILITATION CENTER		RAISO, IN46383	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	·	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
		ated 7/3/11, indicated the	-	assessment and interventions b	
	•	pressure was documented		SDC/designee by 9/30/11.	,,
	at 74.	er pulse was documented			
	Nurses note, dated 7/5/11, indicated the resident's blood pressure was documented			What measures will be put in	l l
				place or what systemic chang	
				you will make to ensure that deficient practice does not re	• • • • • • • • • • • • • • • • • • •
				· Unit Manager/designee	l l
	as 122/70, her pu	ılse was documented as		audit the 24-hour reports daily	• • • • • • • • • • • • • • • • • • •
	72.			clinical meeting (Mon-Fri) for	l l
	Nurses note on 7/23/11 at 4 a.m.,			change in resident condition.	• • • • • • • • • • • • • • • • • • •
				IDT Team will review any resi	l l
	indicated "97.1 (	temperature), 50 (pulse),		with a change of condition for	
	24 (respirations)	, 75/50 (blood pressure)		appropriate intervention and documentation.	
	(normal 120/70)	Coumadin (Warfarin) on		Nursing Manager on c	all will
		g noted, no black tarry		audit the 24-hours report or	
		The record further lacked		Saturday for residents with	a
		o indicate the resident's		change of condition.	
		nd heart rate was being		The IDT Team will rev	<b>I</b>
	monitored the re	_		any resident with a change condition for appropriate	OI
	inomitored the re	st of the fight.		intervention and	
	Nursa nata data	d 7/22/11 10:20 a m		documentation.	
	· ·	d 7/23/11 10:30 a.m.,			
		50 (blood pressure) 54		How the corrective action(	· ·
	(pulse)" The			will be monitored to ensur deficient practice will not i	
	`	ministration Record)		i.e., what quality assurance	• • • • • • • • • • • • • • • • • • •
		ident received her blood		program will be put into pl	• • • • • • • • • • • • • • • • • • •
	1 ^	tion on 7/23/11 and		,	
		.m., of Atenolol 25 mg		· A "24 Hour Condition	• • • • • • • • • • • • • • • • • • •
	along with Vasotec 20 mg. On 7/24/11 at 5:00 p.m., the MAR indicated the resident received her 5:00 p.m. dose of Vasotec 20 mg for blood pressure. The MAR, or the			Report" CQI tool will be utili	zed
				weekly x 4, then monthly	he
				thereafter for 6 months by the Unit Manager/designee.	IIC
				Data will be submitte	d to
	resident's clinica	l record lacked		the CQI Committee for review	<b>I</b>
	documentation to	o indicate the resident's		and follow up. If the thresh	
	blood pressure o	r pulse was checked prior		are not met an action plan v	will be

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		155166	A. BUILDING B. WING		08/31/2011
	PROVIDER OR SUPPLIER	I EHABILITATION CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE  ALL ST  RAISO, IN46383	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	to or after administration pressure medicated. The resident's plaindicated "Problet perfusion related (diagnosis) hyperterve for and document (blood pressure).	istering any of the blood ions.  an of care, dated 6/13/11, em: Ineffective tissue to dx tensionApproachObs iment:variations in B/P	MG	developed.  Noncompliance with far procedures will result in disciplinary action.	
F0323 SS=D	environment rema hazards as is poss receives adequate devices to prevent Based on intervie the facility failed kept free from fa subsequently end room in critical company	ews and record review, to ensure a resident was	F0323	F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES The facility must ensure that resident environment remair free of accident hazards as i possible; and each resident receives adequate supervision	ns as s
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	DJTL11 Facility	ID: 000083 If continuation s	heet Page 19 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155166	B. WIN			08/31/2011
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF F	PROVIDER OR SUPPLIER			606 WA		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER		1	RAISO, IN46383	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	of 4. Resident #	В			and assistance devices to p	revent
					accidents	
	Findings include				What corrective action(s) w	
		•			be accomplished for those	
		cord was reviewed on			residents found to have be affected by the deficient	en
	8/30/11 at 9: 10 a.m. The resident's				practice	
					pradition	
	record indicated diagnoses of, but not				· There is no corrective	
	limited to; Obesity, anemia, dementia,				action for resident #B since	the
	·	congestive heart failure,			alleged deficiency was in the	•
	weakness, history of cerebral vascular accident, impaired renal function, neuropathy, and mitral and aortic valve				and no longer resides at the	
					facility.	
					How will you identify other	,
	stenosis. The resi	ident's record indicated			residents having the poten	
	she was admitted	to the facility on 6/6/11.			to be affected by the same	
		,			deficient practice and what	t
	The resident's red	cord indicated the			corrective action will be tal	
		d to sleep in a recliner				
	_	ring an interview with the			· Residents residing in	
		•			facility have the potential to	
		ing on 8/31/11 at 9:00			affected by the alleged defic practice.	ient
		ed the resident slept in a			The Unit	
		and preferred not to sleep			Manager/designee will revie	w the
		quested the bed to be			Fall Risk Assessment for all	
	removed from he	er room.			residents and updated as	
					needed.	
	A form titled "Fa	ll Risk Assessment,"			The SDC/designee with appropriate transfer staff of the staff of	
	dated 6/6/11, ind	icated the resident was at			complete Inservice for staff of Fall Prevention Interventions	
	· ·	cing a fall. The form			9/30/11.	
	indicated she was experiencing symptoms of acute illness or exacerbation of chronic illness, was incontinent of urine or bowel, was on diuretics and a benzodiazepine, and has an impaired gait /balance.					
					What measures will be put	into
					place or what systemic	
					changes you will make to	
					ensure that the deficient	
					practice does not recur	
					<ul> <li>Unit Managers monitor resident care by making rou</li> </ul>	
	A Physical Thera	py Progress report, dated			Tosident date by making tod	iius

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155166	B. WIN			08/31/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEI	₹		606 WA			
VAI PAR	AISO CARE AND R	EHABILITATION CENTER		1	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	<del> </del>		-	IAU	on their units to ensure fall		DATE
	1	6/19/11 indicated " Fall			interventions are in place.		
	riskReason for continuation: Has				Concerns are addressed with	n the	
		ts in transfers and			nursing aide, as needed.		
	ambulation safet	y." The form indicated			Rounds are completed		
	"Muscle weakness."				shift by the charge nurse, by		
	A Physical Therapy Progress report dated				department heads Monday	-	
					Friday to monitor resident ca Concerns are addressed with		
	1 *	6/26/11 indicated " Fall			aides charge nurse utili		
	riskReason for continuation: Has				an inservice and/or disciplina	-	
	continued deficits in transfers and				action.		
					<ul> <li>The Director of Nursin</li> </ul>		
	ambulation safety." The form indicated "Muscle weakness."				Services is responsible to me		
	Wiuscie weakiie	288.			for facility compliance. Root		
					Cause Analysis will be condute to determine possible cause		
	Review of a for				fall.	°'	
	1	eport," dated 6/26/11 at			· Charge nurses/nursing	9	
	_	nted "Res (resident) was			assistants are responsible to		
	in recliner and tr	ried to scoot out and			ensure residents receive the		
	plopped on the f	loor by mistake. Res has			necessary fall prevention		
	no injuries" 7	The form indicated the			measures that they require.		
	resident did not	have a history of			How the corrective action(	s)	
	orthostatic hypo	tension (low blood			will be monitored to ensure	·	
	pressure moving	from sitting to standing			deficient practice will not re	cur,	
	position.)				i.e., what quality assurance		
	•				program will be put into pla	ice	
	The resident's nl	an of care, dated 6/13/11,			· Observations will be		
	1	em: Fall risk related to			documented on the "Reside Care Rounds" CQI tools we		
		of breath) H/O (history			x 4, then monthly thereafter	-	
	1	· · · · · · · · · · · · · · · · · · ·			· The DNS/designee wi		
	of) fallsThe approaches indicated " Encourage and remind resident to use call light, Fall risk assessment, Observe for fall risk contributors such as medications,				completed the "Fall Manager	ment"	
					CQI tool weekly x 4, then mo	onthly	
					thereafter.	.	
					<ul> <li>Data will be submitted the CQI Committee for review</li> </ul>		
	1	n unsteady gait. Provide			and follow up. Actions plans		
	1	insfers, bed mobility,			be developed for thresholds		
	Refer to therapy	for screening" The			,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 08/31/2	ETED	
		100100	B. WIN		DDDEGG CIEW CELTE ZID CODE	00/31/2	011
NAME OF	PROVIDER OR SUPPLIE	R		606 WA	DDRESS, CITY, STATE, ZIP CODE		
VALPAR		EHABILITATION CENTER		1	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710	<del> </del>	ed to indicate it had been	+	1710	are not met.		DATE
	updated after the fall from her chair on 6/26/11.				· Noncompliance with fa		
					procedures will result in educ	cation	
	0/20/11.				and/or disciplinary action.		
	A care plan, date	ed 6/10/11, indicated					
	"Problem- Resid	lent has short term					
	memory loss"						
	During an interview with the Director of Nursing on 8/31/11 at 10:15 a.m.,						
	regarding the care plan not being updated						
	1	he resident from falling					
	1	gain, she indicated a					
	I -	on for the chair should					
		I since the resident					
	attempted to get	out of it.					
	A Fall Circumsta	ance Report, dated					
	1	ed "Res attempted to					
	transfer self into	shower chair, change in					
	Xanax (antianxi	ety medication), Lexapro					
	(antidepressant)	and Librium ( used for					
	1	damp d/t (due to) shower					
		prior Re-educate staff to					
		res while in shower					
	1	tinue) to provide gentle					
		to please wait for assist					
		The form indicated the					
	1 -	nced an abrasion to her					
	left knee 5 cm (c	centimeters) by 3 cm.					
	During an interv	riew with the Director of					
	1 -	/11 at 10:30 a.m.,					
	1	sident falling on 7/17/11,					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND FLAN	OF CORRECTION	155166		LDING	00	08/31/2	
		100100	B. WIN		DDDECC CITY CTATE ZINCODE	00/01/2	
NAME OF I	PROVIDER OR SUPPLIER			606 WA	DDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		1	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCT)		DATE
		CNA was attempting to					
	give Resident #B a shower. While in the shower room with the floor wet, the CNA						
		and the resident had					
		er wheelchair and fell ion to her knee. The DON					
	_	dated the care plan for					
	1	heir back on the resident.					
		nen back on the resident.					
	Nurses note on 7	/23/11 at 4 a m					
	indicated "97.1 (temperature), 50 (pulse),						
	24 (respirations), 75/50 (blood pressure)						
		Coumadin (Warfarin) on					
	, , , , , , , , , , , , , , , , , , , ,	g noted, no black tarry					
		The record further lacked					
		indicate the resident's					
		nd heart rate was being					
	monitored the res	_					
	Nurse note, dated	d 7/23/11 10:30 a.m.,					
	indicated " 106/5	50 (blood pressure) 54					
	(pulse)" The r	resident's MAR					
	(Medication Adn	ninistration Record)					
	indicated the resi	ident received her blood					
	pressure medicat	ion on 7/23/11 and					
	7/24/11 at 9:00 a	.m., of Atenolol 25 mg					
	along with Vasot	ec 20 mg. On 7/24/11 at					
	1 -	AR indicated the resident					
	received her 5:00	p.m. dose of Vasotec 20					
		ssure. The MAR, or the					
	resident's clinical record lacked						
	documentation to	indicate the resident's					
	_	r pulse was checked prior					
	to or after admin	istering any of the blood					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or connection	155166		LDING	00	08/31/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			606 WA			
VALPAR/	AISO CARE AND RI	EHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
1/10	pressure medicat	·		1710			Ditt
	F						
	Nurse note, dated 7/24/11 at 2:00 p.m.,						
		has increased anxiety.					
		aining of falling. Res					
	_	o transfer self in order					
	not to fall"						
	Nursa nota, datad 7/24/11 at 5 n m						
	Nurse note, dated 7/24/11 at 5 p.m., indicated "Res found lying on (R) (right)						
	side on floor in room laceration to (R)						
		ve (L) (left) eyebrow					
		omplains of) chest pain.					
	`	ER (emergency room)					
		ment MD (medical					
	doctor) and famil	*					
		iy notined.					
	A statement writt	ten by LPN #3, dated					
	7/24/11, indicate	d "Aide called me into					
	resident's room. 1	Resident lying on her					
	right side on the	floor with head near the					
		nit. Resident's right arm					
		rered with blood. Small					
		on floor. Laceration to					
	` ′	and above the left					
	eyebrow noted. Res complained of chest						
	pain"						
	A statement writt	ten by LPN # 4, dated					
		d "Res called out for					
	1	on floor, while another					
	_	g in the tray. Res was					
	· · · · · · · · · · · · · · · · · · ·	. Res had blood on arm					
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. 1355 Had Olood oll dilli					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S	ETED	
		155166	B. WING	G		08/31/2	011
NAME OF PROVIDER OR SUPPLIER			-	STREET A	DDRESS, CITY, STATE, ZIP CODE LL ST		
VALPARA	AISO CARE AND RI	EHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAO		to cuts. Res was fully		IAG			DATE
		was within reach but not					
		presentnurse sent Res					
	to ER 911."	1					
		nce Report form. dated					
	1	indicated the fall was					
	unwitnessed "v	•					
		SResident stated she nt, wasn't able to re-call					
		Reeducation about call					
	light"	Recaucation about can					
	11911						
	During an intervi	iew with the resident's					
	family member of	on 8/30/11 at 12:20 p.m					
		ident's fall on 7/24/11.					
	l ,	ated the resident's entire					
		and blue along with the					
	_	nd behind her ears after					
		a few days after being					
	sent to the hospit						
	Some to the hospit	****					
	During an intervi	iew with the Director of					
	Nursing on 8/31/	11 at 11:30 a.m.,					
		ident's critical protime,					
	_	ssure while taking blood					
	pressure medicat						
		ndicating any blood					
	_	ing was being done, a					
		with the resident being					
		diagnosis of weakness she indicated the nurses					
	· ·	he entire picture related					
	lanea to look at t	and diffine proture related					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2011
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	This Federal tag IN00095374  3.1-45(2)  Each resident's driftom unnecessary drug is any drug w (including duplicat duration; or without adequate is the presence of accountinued; or an reasons above.  Based on a compriresident, the facilities residents who have drugs are not give antipsychotic drugs treat a specific cordocumented in the residents who use gradual dose reduinterventions, unle				
	Based on intervie	ews and record review,	F0329	F329 DRUG REGIMEN IS F	REE 09/30/2011

li '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155166	B. WIN	IG		08/31/2	011
NAME OF	PROVIDER OR SUPPLIEF	3	•	1	ADDRESS, CITY, STATE, ZIP CODE		
				606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPAF	RAISO, IN46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)	+	TAG	·	100	DATE
	1	l to ensure a resident was			FROM UNNECESSARY DRU Each resident's drug regimen m		
		on blood pressure			be free from unnecessary drugs		
		ted to the resident having			unnecessary drug is any drug w		
	a critically low b	plood pressure and not			used in excessive dose (including		
	being monitored	prior to giving two blood			duplicate therapy); or for excess	sive	
	pressure medicat	tions 5 hours later for 1 of			duration; or without adequate		
	4 residents revie	wed with blood pressure			monitoring; or without adequate	e	
	medications in a	sample of 4.			indications for its use; or in the presence of adverse consequence		
		•			which indicate the dose should		
	Resident #B				reduced or discontinued; or any		
					combinations of the reasons abo		
	Findings include						
	i mamgs merade	•			Based on a comprehensive		
	Dagidant # Pla re	ecord was reviewed on			assessment of a resident, the fac	-	
		.m. The resident's record			must ensure that residents who		
					not used antipsychotic drugs are given these drugs unless	e not	
	_	ses of, but not limited to;			antipsychotic drug therapy is		
	1 .	, dementia, atrial			necessary to treat a specific con	dition	
		sestive heart failure,			as diagnosed and documented in		
	1	y of cerebral vascular			clinical record; and residents w	10	
	_	ed renal function,			use antipsychotic drugs receive		
		mitral and aortic valve			gradual dose reductions, and		
	stenosis. The res	ident's record indicated			behavioral interventions, unless clinically contraindicated, in an		
	she was admitted	d to the facility on 6/6/11.			to discontinue these drugs.	CHOIL	
	The resident's Ju	ly 2011 medications					
	include but are n	ot limited to; Atenolol 25			What corrective action(s) will		
	mg (blood pressi	ure) daily at 9:00 a.m. and			accomplished for those resider		
	Vasotec 20 mg (	blood pressure) two times			found to have been affected by deficient practice	tne	
	1	and again at 5:00 p.m.			acticient practice		
					There is no corrective action	on for	
	A nurses note da	ated 7/3/11, indicated the			resident #B since the alleged		
		pressure was documented			deficiency was in the past	and	
	1	er pulse was documented			no longer resides at the facility.		
		puise was documented					
	at 74.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TULTIPLE CON LDING	nstruction 00	(X3) DATE : COMPL	ETED	
		155166	B. WIN			08/31/2	011
NAME OF I	PROVIDER OR SUPPLIEF	2	·	STREET A	DDRESS, CITY, STATE, ZIP CODE LL ST		
		EHABILITATION CENTER		<u> </u>	RAISO, IN46383		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	Nurses note, date resident's blood	ed 7/5/11, indicated the pressure was documented ulse was documented as			How will you identify other residents having the potential affected by the same deficient practice and what corrective action will be taken		
	indicated "97.1 ( 24 (respirations) (normal 120/70) documentation to	7/23/11 at 4 a.m., temperature), 50 (pulse), , 75/50 (blood pressure) " The record lacked o indicate the resident's and heart rate was being st of the night.			Residents residing in the facility have the potential to be affected by the alleged deficien practice.  Nurses will be inserviced the use of unnecessary drugs including assessment and documentation by the SDC/desiby 9/30/11.	t I on ignee	
	indicated " 106/5 (pulse)" The r (Medication Adr indicated the res pressure medicate	ninistration Record) ident received her blood tion on 7/23/11 and			Noncompliance with faci policy and procedure will result employee education and/or disciplinary ac up to and including termination What measures will be put int place or what systemic change you will make to ensure that the	t in ction	
		i.m. of Atenolol 25 mg sec 20 mg. On 7/24/11 at			deficient practice does not rec		
	5:00 p.m., the M received her 5:00 mg for blood president's clinical documentation to blood pressure of to administering medications.	AR indicated the resident 0 p.m. dose of Vasotec 20 essure. The MAR, or the			The Interdisciplinary tear review the 24 Hour Report and Physician Telephone Order form Monday – Friday (excluding holidays) at the clinical meeting. The Unit Ma or designee will ensure implementation and compliance. The charge nurse will no physicians of abnormal blood pressures.	n nager e.	
		ne perfusion related to DX			· Nurses will be inserviced	d on	
	hypertensionO				the use of unnecessary drugs	u VII	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED
155166		A. BUILDING B. WING		08/31/2011	
	SUMMARY S	EHABILITATION CENTER  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN46383  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	document:varia	ations in B/PNotify		including assessment and documentation by the SDC/designee by 9/30/11.	
	risk related to SC weakness, H/O (I fallsApproach contributors such hypotension, pair assistance with the During an interving on 8/31/regarding the respressure while ta medications, the indicating any blook was being done, diagnosis of weak she indicated the the residents entill blood pressure should pressure should be monitored.  According to "Not handbook, 2010 medications the reindicated the follows was been good by the reference; " PC (hour), peak 4-6 Patient monitorir	Deserve for fall risk as medications, as medications, as medications, as medications, as medications, as medicated gait, provide transfers"  The work with the Director of all at 11:30 a.m., ident's critical blood king blood pressure lack of documentation cood pressure monitoring a low pulse, with a kness and recent falls, nurses failed to look at the picture, the resident's mould have been arrived by the following related to the following resident was taking,		How the corrective action(s) we be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place.  The DNS/designee will a the medication administration records and document on the "MAR CQI" Audit tool three times a week x 4 weeks, then month ongoing for compliance.  The audits are provided the Executive Director for rev Noncompliance is discussed we the CQI committee and action plans are developed to improve performance, which will inclue ducation, skills validations, performance improvement, and disciplinary action.  The CQI committee will review data obtained. If three is not achieved, an action plan will developed.	ar, audit andit to iew. ith ace de ad/or

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l	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE C  A. BUILDING  B. WING	00	COMP 08/31/2	LETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET 606 W	ADDRESS, CITY, STATE, ZIP CO ALL ST ARAISO, IN46383	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	diureticsinstruct slowly when sitting avoid dizziness of sudden blood present #B was times daily, a diured Atenolol 25 mg of peaks in 2 hours, monitoring; tell present temporary blood stands or sits uperise slowly and control of the slowly and control of the slowly and control of the slowly when sitting the slowly and control of the slowly when sitting the slowly are slowly when sitting the slowly when sitting the slowly when sitting a slowly when slowl	daily: " Onset 1 hr, duration 24 hrs, pt of that drug may cause a pressure decrease if he suddenly. Instruct him to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION OO O	ON	(X3) DATE S COMPL <b>08/31/2</b>	ETED	
	PROVIDER OR SUPPLIER	I EHABILITATION CENTER	STRE 606	ET ADDRESS, C WALL ST PARAISO, IN	CITY, STATE, ZIP CODE		
		TATEMENT OF DEFICIENCIES	ID	1			(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX		OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-R	REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
F0441 SS=E	The facility must e Infection Control F a safe, sanitary an and to help prever	stablish and maintain an Program designed to provide and comfortable environment and the development and sease and infection.					
	Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should biresident; and (3) Maintains a recorrective actions  (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the recommunicable dislesions from direct their food, if direct disease.	stablish an Infection Control nich it - controls, and prevents cility; crocedures, such as e applied to an individual cord of incidents and related to infections.  read of Infection ction Control Program resident needs isolation to d of infection, the facility					
	which hand washing professional practical (c) Linens Personnel must ha	direct resident contact for and is indicated by accepted ce.  andle, store, process and as to prevent the spread of					
	facility failed to crooms were free	ations and interviews, the ensure the resident's from potential infectious o soiled gloves on the e table and floor	F0441	PREVI The fa mainta Progra	NFECTION CONTROL, ENT SPREAD, LINENS acility must establish ar ain an Infection Control am designed to provide sanitary and comfortab	e a	09/30/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155166			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SU COMPLE 08/31/20	TED	
		155100	B. WIN			08/31/20	11
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	DDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND R	EHABILITATION CENTER		606 WA	RAISO, IN46383		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	`	X and # ZZ), urinals			environment and to help pre-	vent	
	_	sitting on the bedside			development and transmission	on of	
		ents # A, # ZZ and # BB, a			disease and infection.		
	resident's comm	ode with 5 inches of urine					
	in it (Resident #	YY) and soiled linen on					
	the floor for Res	idents # XX and # CC.			What corrective action(s) w	/III	
	This deficient pr	actice has the potential to			be accomplished for those residents found to have be	_	
	affect all residen	ts residing in the facility.			affected by the deficient	-	
					practice		
	Findings include	::			-		
					· Observations were ma		
	During a tour of	the facility on 8/30/11 at			of all rooms to ensure urinals		
	8:00 a.m., accompanied by the Staff				commodes were emptied, lin from floor and gloves were	ien	
		oordinator # 6, the			removed.		
	_	vations were made:					
	l lone wing coser (	ations were made.			How will you identify other		
	1 Resident # Y	X's room was observed to			residents having the potent	tial	
		oves on the floor. The			to be affected by the same deficient practice and what		
	_	ed inside out as if they			corrective action will be take		
	1 -	ed. Resident # XX's room					
		have a pile of soiled bed			· All residents have the		
		-			potential to be effected by th	e	
		r. The Staff Development			alleged deficient practice.  Observations were ma	ndo	
		summoned staff to pick			of all rooms to ensure urinals		
	the linen up off of	of the floor.			commodes were emptied, lin		
	0 D	9. 1 1 1. 4. 1. 1.			from floor and gloves were		
		's bedside table was			removed.		
		e a urinal containing 2			<ul> <li>All staff will be educated infection control as to the</li> </ul>	ea on	
		n it and soiled gloves next			appropriate cleaning of urina	ıls,	
	to the urinal on t	he table.			bedside commodes and		
					transferring of soiled linen by	/ the	
		s room was observed to			SDC/designee by 9/30/11.		
		his bedside table one			What measures will be put	into	
	fourth full of uri	ne.			place or what systemic changes you will make to		
					Shanges you will make to		

<b>i</b>		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155166	B. WIN			08/31/2011
NAME OF I	PROVIDER OR SUPPLIER	ш	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
MANIE OF I	NO VIDER OR SUITER			606 WA		
VALPAR	AISO CARE AND RI	EHABILITATION CENTER		VALPAF	RAISO, IN46383	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		's bedside table was			ensure that the deficient practice does not recur	
		a urinal three quarters			practice does not recui	
	full of urine.				· The SDC/designee wi	ı
		_			make infection control round	s and
	5. Resident # YY				document on the "Infection	
		5 inches of urine in the			Control Review" form at leas times weekly for 4 weeks, the	l l
		t. During an interview			once weekly there after.	~··
		opment Coordinator # 6			Rounds are completed	
		she indicated staff are to			routinely each shift by the ch	
	_	les and urinals empty and			nurse, by Customer Care Re Monday - Friday to monitor	ps
	clean. She further	r indicated a small			resident care. Concerns are	
	amount of soap s	hould be placed in the			addressed with the aides cha	
	commode after c	leaning to aid in			nurse.	
	preventing odors	. On 8/31/11 at 11:45				.
	a.m., the resident	s's commode was			How the corrective action(s	· I
	observed again c	ontaining 2 inches of			will be monitored to ensure deficient practice will not re	· ·
	urine.				i.e., what quality assurance	
					program will be put into pla	
	6. Resident # CC	s room was observed to				
	have a pile of soi	led bed linen on the			· Observations from rou	inds
	resident's floor.				will be documented on the "Infection Control Review" C	oı l
					tool weekly x 4, then monthly	l l
	During an intervi	iew with the Director of			thereafter by the DNS/design	nee.
	Nursing on 8/31/				Data will be submitted	
	_	ove issues, she indicated			the CQI Committee for review and follow up. Action plans	l l
		ommodes are to be			be developed if the threshold	
		ately and washed by staff.			not obtained.	·
	-	ere should not be any			· Noncompliance with fa	acility
		or urine being left in			procedures will result in	
	commodes or uri	•			disciplinary action.	
		should not be on the				
	resident's bedside					
	1051delit 5 ocusius					
	This Federal tag	relates to Complaint #				
FORM CMS-2	567(02-99) Previous Versio		DJTL11	Facility I	ID: 000083 If continuation s	heet Page 33 of 34

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	li i	e survey pleted /2011
		EHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP ALL ST RAISO, IN46383	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE )	(X5) COMPLETION DATE
TAG	REGULATORY OR IN00095374  3.1-18(b)(1)	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE